STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

December 8, 1982

ALL-COUNTY INFORMATION NOTICE I-158-82

TO: ALL COUNTY WELFARE DEPARTMENTS
ALL PUBLIC AND PRIVATE ADOPTION AGENCIES
ALL DEPARTMENT OF SOCIAL SERVICES ADOPTION DISTRICT OFFICES

SUBJECT: ADOPTION ASSISTANCE PROGRAM FORMS

This notice is to provide you with a copy of four new forms that are to be utilized in conjunction with the new Adoption Assistance Program. They are required as a result of passage of AB 2695 (Chapter 977, Statutes of 1982) and the resultant emergency regulations, both of which were effective October 1, 1982.

AD 4320	(9/82)	Adoption Assistance Agreement	-	To be used whenever Adoption Assistance is granted or may be required in the future.
AAP 1	(9/82)	Request for Adoption Assistance	-	To be used by adoptive parents to request benefits under the Adoption Assistance Program. (C.A.C. Section 30671 (a)).
AAP 2	(9/82)	Payment Instructions Adoption Assistance Program	-	To be used by the licensed adoption agency to instruct the county to commence or change Adoption Assistance Program benefits. (C.A.C. Section 30671 (c)).
AAP 3	(9/82)	Recertification Information - Adoption Assistance Program	-	To be transmitted by the County to the adoptive parents for completion during the recertification process. (C.A.C. Section 30671 (g)).

The 9/82 draft of the Adoption Assistance Agreement inadvertently omitted two provisions which will require a later amendment of the form. Until the form can be amended, agencies will need to include the following addenda when completing the AD 4320:

1. I/we understand that the child will not be eligible to receive Adoption Assistance Program benefits after he/she reaches the age of 18 years unless he/she has a mental or physical handicap which warrants continuation of payment to the age of 21 years.

2. I/we understand that state law prohibits the payment of an adoption assistance benefit which exceeds the amount which would have been paid for the child in foster care. I/we agree that if foster care rates are reduced to an amount less than that specified by this agreement, the amount of adoption assistance benefits will be reduced to the amount which would have been paid for the child in foster care.

Two additional forms FC 8 (Federal Eligibility Certification for Adoption Assistance Program) and FC 9 (Federal Eligibility Information for Adoption Assistance Program) will be transmitted to all agencies shortly.

Local agencies may utilize the attached forms until they become available through the Department warehouse. The AAP 1 and AAP 3 will come in pads of 25 sheets; the AAP 2 and AD 4320 will come in NCR sheets. All of these forms should be ordered after November 1982 on the Form GEN 727-B from the State Department of Social Services Warehouse, P. O. Box 22429, Sacramento 95822. Revised versions of these forms will be available as the supply of each form is exhausted.

If there are any questions regarding this notice, please contact your adoption program consultant.

CLAUDE FINN
Deputy Director
Adult and Family Services Division

Attachment

cc: CWDA

ADOPTION ASSISTANCE AGREEMENT

DISTRIBUTION:

Original : Adoptive Applicants
Copy : Agency File

Complete Section I **or** *II as appropriate*

SECTION I

I/we, _____ (NAME OF PARENT) and _____ (NAME OF PARENT), have entered into an agreement with the _____ (NAME OF AGENCY) for adoption assistance for _____ (NAME OF CHILD).

The amount of assistance is $ _____ per month. Under the terms of this agreement, payment is authorized from _____ (BEGINNING DATE OF PAYMENT) until _____ (ENDING DATE OF PAYMENT).

I/we agree to keep the _____ (NAME OF AGENCY) informed of any changes in my/our financial circumstances or the needs of the child.

I/we understand that, with my/our concurrence, the adoption agency may increase or decrease the amount of adoption assistance benefits as my/our circumstances or the needs of the child change.

I/we ageee to keep the _____ (NAME OF AGENCY) informed of my/our place of residence and current address until termination of adoption assistance.

I/we understand that adoption assistance payments are normally authorized for two years at a time, and that _____ (COUNTY WELFARE DEPARTMENT) will send us forms for the recertification of this agreement prior to the end of that period. I/we understand that failure to provide the necessary information may result in the delay of continued Adoption Assistance Program benefits.

I/we understand that continuation of adoption assistance payments depends upon my/our legal responsibility for the support of the child and of continued receipt of that support by the child.

I/we understand that this agreement shall remain in effect regardless of the state of which I/we are residents.

I/we understand that under the terms of this agreement the child is eligible for services under Titles XIX (Medi-Cal) and XX (Social Services) of the Social Security Act.

CONFIRMATION OF ADOPTION ASSISTANCE PROGRAM CRITERIA: (Check One)				ADOPTIVE PARENT SIGNATURE	DATE
☐ Age	☐ Sibling Group Member	☐ Minority Ethnicity	☐ Health Problem		
AGENCY REPRESENTATIVE SIGNATURE		DATE		ADOPTIVE PARENT SIGNATURE	DATE

SECTION II

I/we, _____ (ADOPTIVE PARENT) and _____ (ADOPTIVE PARENT), understand that _____ (NAME OF CHILD) has _____ (MENTAL OR PHYSICAL HANDICAP) which may result in a future need for Adoption Assistance Program benefits. Although assistance is not needed at this time, I/we understand that, after completion of the adoption, if I/we are unable to meet the child's need related to this physical or mental handicap, I/we may request Adoption Assistance Program benefits.

ADOPTIVE PARENT SIGNATURE	DATE	ADOPTIVE PARENT SIGNATURE	DATE
AGENCY REPRESENTATIVE SIGNATURE		DATE	

REQUEST FOR ADOPTION ASSISTANCE

I/We, _____ (NAME OF PARENT) and _____ (NAME OF PARENT), are considering adopting _____, born _____ (DATE OF BIRTH). Our circumstances and the child's needs are such that I/we will require financial and/or medical assistance under the Adoption Assistance Program in order to agree to adopt this child.

Check (✔) one of following:

☐ I/We do not require assistance at this time, but wish to complete an agreement with the agency which shall permit such assistance at a later time, due to the child's known medical condition or physical, mental or emotional handicap.

☐ I/We will require assistance as soon as an interlocutory decree of adoption is obtained, and are providing the following information to assist the agency in determining whether assistance may be provided, and in what amount. I/We understand that for assistance to be provided, the agency and I/we must agree on the amount, timing and duration of the assistance.

1. The number of persons in the household dependent on my/our support, not including the child to be adopted ..... _____

2. **MONTHLY INCOME**

Gross Wages ..... $ _____

Net Wages *(specify all non-mandatory deductions)* _____ $ _____

_____

Other Income *(interest, property, dividends, etc.)* ..... $ _____

Total Income ..... $ _____

3. **PRESENT MONTHLY EXPENSES**

Ongoing *(pro-rate those that occur at other intervals, such as annually)* ..... $ _____

Housing *(including taxes and insurance)* ..... $ _____

Utilities ..... $ _____

Medical ..... $ _____

Insurance ..... $ _____

Clothing ..... $ _____

Food ..... $ _____

Loans and Bank Card Payments ..... $ _____

Car Expenses *(gas, oil, repair)* ..... $ _____

Other *(specify)* _____ $ _____

Total Present Monthly Expenses ..... $ _____

4. **NET INCOME** *(Item 2 total minus Item 3 total)* $ _____

5. **OTHER RESOURCES**

Savings ..... $ _____

Bonds ..... $ _____

Checking Account(s) ..... $ _____

Stocks ..... $ _____

Investments ..... $ _____

Real Property *(Equity)* ..... $ _____

Life Insurance *(Face Value)* ..... $ _____

Total Other Resources ..... $ _____

6. **INSURANCE**

a. Health/Hospitalization

Family has health and hospitalization insurance? ..... YES ☐ NO ☐

Child placed with family will be covered by insurance: *(Check one of the following)*

☐ At the time of adoptive placement.

☐ Not until the adoption is finalized.

b. Life

Family has life insurance? ..... YES ☐ NO ☐

If YES, complete the following:

NAMES(S) OF PERSON(S) COVERED	DATE ISSUED	INSURED AMOUNT	CASH SURRENDER VALUE

SIGNATURE OF ADOPTING MOTHER ▶

DATE

SIGNATURE OF ADOPTING FATHER ▶

DATE

PAYMENT INSTRUCTIONS
ADOPTION ASSISTANCE PROGRAM

DISTRIBUTION:

Original : County Welfare Department
Copy : Agency File

COUNTY CASE NUMBER
STATE ADOPTIONS CASE NUMBER ADA
ADOPTION AGENCY CASE NUMBER

CHILD'S NAME	CHILD'S BIRTHDATE

This is a: *(Check applicable item(s))*

- ☐ New case; Form FC 9, Federal Eligibility Information is attached.
- ☐ Change in child's name, payee name or address.
- ☐ Change in amount or duration of payment due to: *(Check (✓) one)*
  - ☐ Completed recertification *(change due date).*
  - ☐ Change in need or circumstances *(do not change due date).*
  - ☐ Ineligibility due to _____ (REASON FOR NOTICE OF ACTION)

I certify that this child is eligible for Adoption Assistance Program payments; **please start** or change payments as follows: $_____ per month effective _____ (BEGINNING DATE OF PAYMENTS OR EFFECTIVE DATE OF CHANGE) *

The last month of payment shall be _____ (ENDING MONTH OF PAYMENT).

PAYEE NAME	If child were placed in foster care, rate of payment would be: *(Check (✓) one)*
PAYEE ADDRESS (NO.) (STREET)	☐ Family Home rate of $_____.
(CITY) (STATE) (ZIP)	☐ Other rate of $_____. *(Describe type of care)*_____

SIGNATURE OF AUTHORIZED OFFICIAL OF FAMILY'S ADOPTION AGENCY ▶		SIGNATURE OF AUTHORIZED OFFICIAL OF CHILD'S ADOPTION AGENCY ▶	
FAMILY'S ADOPTION AGENCY MAILING ADDRESS		CHILD'S ADOPTION AGENCY MAILING ADDRESS	
TELEPHONE NUMBER	DATE	TELEPHONE NUMBER	DATE

*This date should always be the 1st of a month unless it is the date of an interlocutory decree.

RECERTIFICATION INFORMATION
ADOPTION ASSISTANCE PROGRAM

CHILD'S NAME
CHILD'S DATE OF BIRTH

DATE

The purpose of this form is to provide the adoption agency with an update on your circumstances and the needs of the child for whom you are receiving Adoption Assistance Program payments and Medi-Cal coverage. Please complete this form and send it, as soon as possible, to:

NAME OF ADOPTION AGENCY
ADDRESS
TELEPHONE ( )

Check (✓) one of the following:

☐ I/We no longer wish to receive Adoption Assistance Payments and/or Medi-Cal coverage for the above-named child at this time. If the need for benefits arises again, I/we may contact the adoption agency at that time.

☐ I/We and the above-named child continue to need benefits of the Adoption Assistance Program and are supplying the information below to assist the agency in determining whether or not assistance shall continue, and if so, in what amount. I/We understand that failure to complete and forward this form within two weeks *(14 days)* of the date it was mailed to me/us may cause interruption

The number of persons in the household dependent on my/our support, including the above-named child, is_____. I/we remain legally responsible for the support of the above-named child and, in fact, am/are continuing to provide such support.

(Continued on Reverse)

1. MONTHLY INCOME

Gross Wages ..... $ _____

Net Wages *(specify all non-mandatory deductions)* _____

_____ $ _____

Other Income *(interest, property, dividends, etc.)* ..... $ _____

Total Income ..... $ _____

2. PRESENT MONTHLY EXPENSES

Ongoing *(Pro-rate those that occur at other intervals, such as annually)* ..... $ _____

Housing *(Including taxes and insurance)* ..... $ _____

Utilities ..... $ _____

Medical ..... $ _____

Insurance ..... $ _____

Clothing ..... $ _____

Food ..... $ _____

Loans and Bank Card Payments ..... $ _____

Car Expenses *(gas, oil, repair)* ..... $ _____

Other (specify)_____ $ _____

Total Present Monthly Expenses ..... $ _____

3. NET INCOME *(Item 1 total minus Item 2 total)* $ _____

4. OTHER RESOURCES

Savings ..... $ _____

Bonds ..... $ _____

Checking Account(s) ..... $ _____

Stocks ..... $ _____

Investments ..... $ _____

Real Property *(equity)* ..... $ _____

Life Insurance *(face value)* ..... $ _____

Total Other Resources ..... $ _____

5. INSURANCE

a. Health/Hospitalization

Family has health and hospitalization insurance? ..... Yes ☐ No ☐

Child placed with family will be covered by insurance: *(Check (✓) one of the following):*

☐ At the time of adoptive placement.

☐ Not until the adoption is finalized.

b. Life

Family has life insurance ..... Yes ☐ No ☐

If Yes. complete the following:

NAME(S) OF PERSON(S) COVERED	DATE ISSUED	INSURED AMOUNT	CASH SURRENDER VALUE

SIGNATURE OF MOTHER ▶

DATE

SIGNATURE OF FATHER ▶

DATE